Hematology Oncology Consultants of Florida

Suneeta Pinnamaneni, MD
Leesburg & Lady Lake

NEW PATIENT REGISTRATION

Referring Provider

_____
(Doctor or Patient)

_____
(Doctor's Phone Number)

_____
(Purpose of Visit)

***Required Field**

*Patient's Name: _____ Suffix: _____
First Middle Last

*Gender: ☐Male ☐Female ☐Transgender SS# _____ *Date of Birth: _____

*Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated *Preferred Language: _____

*Race: ☐Caucasian ☐American Indian ☐Asian ☐African American ☐Hispanic ☐Other: _____

*Ethnic Group: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Refused to report

*Home Phone: _____ Cell Phone: _____

*Physical Address: _____ *City/State/Zip: _____
(NO PO BOXES)

☐Mailing Address same as Physical Address *E-mail Address: _____

Mailing Address: _____ City/State/Zip: _____

*Primary Care Physician: _____ Office Phone: _____

*Preferred Pharmacy: _____ Pharmacy Phone: _____

*Preferred Laboratory: _____

*Are you employed? ☐Full-time ☐Part-time ☐Unemployed ☐Retired ☐Disabled ☐Homemaker

*Current Occupation / Profession Before Retirement: _____

*Employer: _____ Employer Phone: _____

INSURANCE INFORMATION:

(PLEASE PRESENT INSURANCE CARD & PHOTO ID FOR COPYING)

Primary Insurance: _____ Address: _____ Phone Number: _____

Policy #: _____ Grp #: _____ Relation to policy holder: _____

Policy holder: _____ DOB: _____ Phone: _____

Secondary Insurance: _____ Address: _____ Phone Number: _____

Policy #: _____ Grp #: _____ Relation to policy holder: _____

Policy holder: _____ DOB: _____ Phone: _____

EMERGENCY CONTACT (NOT LIVING WITH YOU):

Name: _____ Relationship: _____ Phone Number: _____

Patient Acknowledgment: I understand that I have the right to accept and refuse medical treatment and to exercise my right and implement an Advanced Directive. An "Advanced Directive" refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and cannot communicate your wishes. Please check the statements below that apply to you:

☐ I have not executed an Advanced Directive

☐ I have executed an Advanced Directive and have/will provide3 a copy to Hematology Oncology Consultants of Florida.

If Yes: ☐ Living Will
☐ Durable Medical Power of Attorney
☐ Do Not Resuscitate (DNR) Order
☐ Designation of Health Care Surrogate form Designee/Guardian:_____

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____ **DATE:** _____

Hematology Oncology Consultants of Florida

Suneeta Pinnamaneni, MD
Leesburg & Lady Lake

NEW PATIENT REGISTRATION

_____
Patient Name

_____
Birthdate

Financial Policy & Assignment of Benefits:

*I understand that it is my responsibility to provide to Hematology Oncology Consultants of Florida / Suneeta Pinnamaneni, MD the accurate billing information at the time of check-in and to notify this office of any changes to this information.
* As a courtesy we will file your primary and secondary insurance. It is your responsibility to make sure that your insurance company has your proper name, most recent address and contact information.
* We are required to make a copy of your insurance cards for verification purposes.
* We will collect your deductible, co-payment and uncovered services fees at the time of service. Payment methods are: Cash, Check, Master Card, Visa, and Discover.
*Your insurance will send you an explanation of benefits that explains what they have paid to our office. This is a record that you must keep on file. If you do not agree with their payment, please contact the insurance company directly.
*If payment is not received within 30 days of the filing date with your insurance you will be notified that payment is due.
*If you are sent outside of the office for additional testing such as lab work or imaging, that facility will file your insure for you. If you have questions regarding billing or claim payment, call the facility directly. We do not have information regarding billing outside of this office.
*We realize it may be necessary on occasion to arrange installment or other payment programs. If financial problems arise, please contact our Patient Account department as soon as possible at 352-343-7246.

Lifetime Authorization for Insurance Assignments and Authorizations to Release Information

*Release of Information: I the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payer (such as insurance company or government agency, example: Blue Cross or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.
*Physician Insurance Assignment: I below named subscriber, hereby authorize payment directly to any physician examining me of any group and group and/or individual surgical and/or medical benefits here in specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for their services.
*Medicare/Medicaid: Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carriers any information needed for this of related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.
*I permit a copy of these authorizations and assignments to be used in place of the original which is on file at the physicians' office. This assignment will remain in effect until revoked by me in writing. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it is my responsibility to pay the deductible amount, co-insurance, or any other balance not paid for by insurance or third payer within a reasonable period of time not to exceed 60 days.
*If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.
*I understand that it is my responsibility to know any specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services bring rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they a.re required to report lo the carrier any enrollees failing to pay the co-pay.

*I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $25 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check or credit card.
*I understand that the office will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any elective procedure that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my elective procedure. I further understand that THE FEE I AM QUOTED JS AN ESTIMATE based on: I) anticipated procedure to be performed and 2) current information provided to clinic by my insurance carrier.
*I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/deductibles) and I have a financial responsibility to pay these amounts. I understand that I will be provided with three (3) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest, or legal expenses associated with the collection efforts.
*I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
*I understand that the clinic may also take a verbal request to use my listed credit card for payment on my account or they may also use the same listed credit card on my account should my account become delinquent, or to cover an NSF check.
*Notice for cancellation of office visits and procedures, must be given 24 hours in advance.

_____I hereby authorize the payment of medical benefits to Hematology Oncology Consultants of Florida / Suneeta Pinnamaneni, MD for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
_____I further agree to pay any and all collections costs, attorney fees, and other collection costs that may be incurred to enforce the collection of any amounts outstanding.
_____I hereby authorize Hematology Oncology Consultants of Florida / Suneeta Pinnamaneni, MD to release any medical information necessary to complete and process my insurance claims.
_____I authorize Hematology Oncology Consultants of Florida / Suneeta Pinnamaneni, MD to treat me and use my personal information for healthcare operations.

My signature below confirms that I have read the above billing policies and my financial obligation as pertaining to this office.

Date: _____

Patient Printed Name: _____ Patient Signature: _____

Witness Printed Name: _____ Witness Signature: _____

Hematology Oncology Consultants of Florida

Suneeta Pinnamaneni, MD
Leesburg & Lady Lake

NEW PATIENT REGISTRATION

_____
Patient Name

_____
Birthdate

☐Male ☐Female

Before my illness began, I would describe my overall health as: ☐Excellent ☐Good ☐Fair ☐Poor
At the present time, I feel: ☐Excellent ☐Good ☐Fair ☐Poor

CHECK ALL SYMPTOMS EXPERIENCED IN THE LAST -3- MONTHS

Constitutional
- ☐ Weight loss
- ☐ Change in appetite
- ☐ Fever
- ☐ Chills
- ☐ Fatigue

Gastroenterology
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Change in stools
- ☐ Difficulty swallowing
- ☐ Hemorrhoids
- ☐ Stool incontinence

Ear/Nose/Throat
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Voice change
- ☐ Mouth sores
- ☐ Sore throat
- ☐ Nose bleeds
- ☐ Taste change

Allergy
- ☐ Runny nose
- ☐ Scratchy throat
- ☐ Sinus congestion
- ☐ Post nasal drip

Urology
- ☐ Frequency at night
- ☐ Difficulty/Pain urinating
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Incontinence

Respiratory
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing/Asthma

Neurology
- ☐ Headache
- ☐ Tingling or Numbness
- ☐ Memory loss
- ☐ Gait abnormalities

Endocrinology
- ☐ Increased thirst
- ☐ Increased urination
- ☐ Cold intolerance
- ☐ Heat intolerance

Musculoskeletal
- ☐ Joint stiffness
- ☐ Joint pain
- ☐ Joint swelling

Cardiology
- ☐ Chest pain
- ☐ Discomfort/Tightness
- ☐ Palpitations
- ☐ Ankle swelling
- ☐ Short of breath lying flat
- ☐ Fainting/Syncope

Hematology/Lymph
- ☐ Swollen glands
- ☐ Easy bruising
- ☐ Night sweats

Dermatology
- ☐ Rash
- ☐ Hives

Ophthalmology
- ☐ Decreased vision
- ☐ Loss of vision
- ☐ Double vision

Date of Last:

Colonoscopy_____ Endoscopy_____ Mammogram_____ Bone Density Test_____

FAMILY HISTORY - CHECK ALL THAT APPLY								
	Age	Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer
Father		Y / N						
Mother		Y / N						
Paternal Grand Father		Y / N						
Paternal Grand Mother		Y / N						
Maternal Grand Father		Y / N						
Maternal Grand Mother		Y / N						
Sibling M / F ?		Y / N						
Sibling M / F ?		Y / N						
Sibling M / F ?		Y / N						
Sibling M / F ?		Y / N						
Child M / F ?		Y / N						
Child M / F ?		Y / N						
Child M / F ?		Y / N						
Child M / F ?		Y / N						

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Patient Name _____

Birthdate _____

CHECK ALL THAT APPLY TO YOUR PAST MEDICAL HISTORY

X	CONDITION	ADDT'L INFO
	Prior/Recent Cancer	
	Chemotherapy	
	Radiation Therapy	
	Other Treatment	
	Skin Cancer	
	Basal cell	
	Squamous cell	
	Melanoma	
	Blood Disorders	
	Sickle Cell Disease/Trait	
	Thalassemia/Other	
	Anemia	
	Blood Transfusions	
	Cardiology	
	High Blood Pressure	
	CAD/MI	
	Angina	
	Atrial Fibrillation	
	High Cholesterol / Triglycerides	
	Other	
	Endocrine	
	Diabetes	
	Hypo / Hyper-Thyroidism	
	Other	
	Gastrointestinal	
	Gastric/Duodenal Ulcer	
	GERD	
	Colitis / Ulcerative / Cohn's	
	Hepatitis A, B, C	
	Cirrhosis	
	GI Bleeding	
	Other	
	Psychological	
	Depression	
	Anxiety	
	Other	

X	CONDITION	ADDT'L INFO
	Genitourinary	
	Recurrent Bladder Infections	
	Renal Insufficiency	
	Other	
	HEENT	
	Cataracts	
	Glaucoma	
	Other	
	Musculoskeletal	
	Rheumatoid Arthritis	
	Osteoarthritis	
	Osteoporosis	
	Other	
	Neurological	
	Stroke	
	Mini-Stroke / TIA	
	Other	
	Pulmonary	
	COPD	
	Asthma	
	Other	
	Men only	
	BPH (Enlarged Prostate)	
	Other	
	Women only	
	Uterine problems	
	Ovarian problems	
	Other	
	POST-Menopausal HRT	
	Hormone Replacements	
	Other	
	PRE-Menopausal	
	Abnormally Heavy Periods	
	Other	

Surgical History:

Procedure _____ Date:_____
Procedure _____ Date:_____
Procedure _____ Date:_____
Procedure _____ Date:_____

Procedure _____ Date:_____
Procedure _____ Date:_____
Procedure _____ Date:_____
Procedure _____ Date:_____

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_____
Patient Name

_____
Birthdate

Smoking: Do you currently smoke? ☐Yes ☐No Have you smoked in the past? ☐Yes ☐No
When did you stop smoking? _____ Average number of packs per day? _____
Mark all that apply: ☐Pipe ☐Cigars ☐Snuff ☐Chewing Tobacco
If a non-smoker, were you exposed to second-hand smoke? ☐Yes ☐No

Alcohol: Do you currently drink alcohol? ☐Yes ☐No
If you do not currently drink, did you consume alcohol in the past? ☐Yes ☐No
Do you drink more often than social occasions? ☐Yes ☐No
What type of alcohol/per ounces/per week? Beer _____ Wine _____ Liquor _____
Has drinking ever interfered with your personal or professional life? ☐Yes ☐No
Drug History: Do you use recreational drugs? ☐Yes ☐No If so, what type: _____

Personal History: Do you have children? ☐Yes ☐No Do they live nearby? ☐Yes ☐No
Do you live alone? ☐Yes ☐No Do you have friends/family nearby to help you during your illness? ☐Yes ☐No
Are you having difficulty functioning at home as a result of your illness? ☐Yes ☐No
Do you permanently reside in Central Florida? ☐Yes ☐No If not, where else do you live? _____

Allergies: Allergen: _____ Reaction:_____ / Allergen: _____ Reaction:_____
Allergen: _____ Reaction:_____ / Allergen: _____ Reaction:_____
☐-No Known Allergies

CURRENT MEDICATIONS		
Drug Name	**Dose** (Miligrams/Units)	**Frequency** (Daily, 2xDaily, Nightly, With Meals)

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NEW PATIENT REGISTRATION

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION .PLEASE REVIEW IT CAREFULLY.

My office is required by federal regulation, known as the HIPPA Privacy Rule; to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. My office will not disclose your health information except as described in this Notice.
The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. The health information about you is documented in a medical record and on a computer. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment, and applying for future care of treatment. It also includes billing documents for those services.

OUR COMMITMENT TO YOUR PRIVACY:
My office is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realized that these laws are complicated, but we must provide you with the information.

WHO HAS ACCESS TO THIS INFORMATION?
Any person or persons who designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for my services has access to your Protected Health Information.
Entities such as Governmental Oversight agencies, Judicial and Administrative Proceeding, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by Law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:
We release your information on to those who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities that need this information for claims processing have access to your Protected Health Information.

YOUR RIGHTS:
You have the right to inspect your Protected Health Information. You also have the right to amend any errors you may find in your records.

DISCLOSURE AND CONSENT:
I have been given the opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risk of non-treatment, the procedures used, and the risks and hazards involved, and 1believe that I have sufficient information to give this informed consent.

Please name all person(s) we can contact and/or discuss your medical information:

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

I hereby understand and accept the above criteria:

Printed Name: _____ **Date:**_____

Legal Signature: _____

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NEW PATIENT REGISTRATION

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize Pain and Spine Centers of Florida to obtain the health information of the individual named below:

Patient Name: _____ **DOB:** _____ **SS#:**_____

Address: _____ **Phone:** _____

I authorize the information to be disclosed to and used by the following individual or organization:

Hematology Oncology Consultants of Florida
8136 Centralia Court, Suite 103
Leesburg, FL 34788
Phone: (352) 343-6900 Fax#: (352) 343-7159

For the purpose of: Continuity of care with medical evaluation and treatment
The type and amount of information to be disclosed is as follows: {specify date where appropriate)

☐Copy of Complete Medical ☐X-ray/MRI/CT Films

☐Laboratory Reports ☐X-ray/CT Scan/MRI Reports

RECORDS TO BE RELEASED FROM: (List doctor or facility to request from.)

_____

_____

_____

_____

PHONE: _____ **FAX:** _____

PURPOSE OF DISCLOSURE: *We may use and disclose your medical records only for each of the following purposes: (]) Treatment, (2) Payment, and (3) Health care operations. We may also create and distribute de-identified health information by removing all references to individually identifiable information.*

REVOCATION RIGHTS: *I certify that 1hi1, request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that J may revoke this authorization m any time by sending a written Notice of revocation to Releaser. I understand that the revocation will become effective upon receipt by Releaser. Any health information disclosed by Releaser pursuant to this Authorization, before the effective date of the revocations is not subject to revocation.*

Patient Signature: _____ **Date:** _____